Medicaid Enterprise

Iowa Department of Human Services

Behavioral Health Services Provider Manual

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Medicaid Enterprise

Iowa Department of Human Services

III. Provider-Specific Policies

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CHAPTER III. COVERAGE AND LIMITATIONS

A. CLINICIANS ELIGIBLE TO PARTICIPATE

The following clinicians are eligible to enroll and provide assessment and treatment planning:

- Those licensed by the Board of Social Work pursuant to 645 IAC Chapter 280 as independent social workers.
- Those licensed by the Board of Social Work pursuant to 645 IAC Chapter 280 as master social workers who:
  - Hold a master's or doctoral degree as approved by the Board of Social Work; and
  - Provide treatment under the supervision of an independent social worker licensed pursuant to 645 IAC 280.
- Those licensed by the Board of Behavioral Science pursuant to 645 IAC Chapter 31 as marital or family therapists.

Clinicians in other states are eligible to participate when they are duly licensed to practice in that state.

B. COVERED SERVICES

Payment will be approved for services as authorized by state law and within the scope of practice of the clinician's license. Services can be provided if:

- The member's diagnosis is not covered by the Iowa Plan, or
- The member is not an Iowa Plan enrollee.

Payment will be approved for services provided by the clinician in the clinician's office, a nursing home, the member's home, or a residential facility.

Payment shall be made only for time spent in face-to-face services with the client. No payment shall be made for services not rendered personally by the clinician.

1. Assessment

The assessment is a diagnostic tool for gathering information to:

- Establish or support a diagnosis, and
- Provide the basis for the development or modification to the treatment plan and development of discharge criteria.

Components of a clinical assessment include:

- Client demographic information
- Presentation/complaint
- Medical history and medications
- Treatment history
- Substance use history
- Mental status
- DSM diagnosis
- Functional assessment (with age-appropriate expectations)

2. Diagnosis

Assign a multi-axis diagnosis or diagnostic impression in accordance with the current edition of the International classification of Disease, Ninth Revision (ICD-9).

Report only diagnostic codes that are clearly and consistently supported by the documentation in the record. Information relating to a diagnosis that is over 12 months old needs to be confirmed.

If the diagnosis is in the range of ICD-9 codes 290 to 309 or 311 to 314, treatment must be covered through the Iowa Plan. If you are not part of the Iowa Plan network, refer the member to an Iowa plan network provider. If you need additional information, contact the Iowa Plan at 1-800-638-8820 or www.magellanhealth.com.

3. Treatment Plan

A treatment plan is a required document in the file. Treatment plans should be individualized to reflect the member's unique needs and goals. The plan must be developed based on a diagnostic evaluation that:

- Includes examination of the medical, psychological, social, behavioral, and developmental aspects of the member's situation, and
- Reflects the need for services.

Treatment plans should include:

- Client specifics, incorporating client goals, needs resources, abilities, and outcomes
- Motivation for change
- Functional impairments to be addressed
- Measurable objectives and goals to determine functional improvement
- Parties responsible for each measurable goal or outcome
- Timeline for goal achievement based on specific needs, resources, abilities of client
- Barriers to goal achievement
- Coordination of treatment with other agencies or treatment providers
- Estimated discharge date

4. Treatment

Treatment must be consistent with generally accepted professional medical standards. Services must be:

- Individualized,
- Specific,
- Consistent with the symptoms or confirmed diagnosis of the illness under treatment, and
- Not in excess of the member's needs.

Payment will be approved for the following:

- Individual outpatient services
- Couple, marital, family, or group outpatient services
- Reassessment, including:
  - The assessment of current symptoms and behaviors related to the diagnosis and of progress toward treatment goal,
  - Justification of changed or new diagnosis, and
  - Response to other concurrent treatments such as medications.

Upon discharge, provide to the member final recommendations including further services and providers, if needed, and activities recommended to promote further recovery. Keep a copy in the member's file.

5. Exclusions

Payment will not be made for the following:

- Services performed without relationship for a specific condition, risk factor, symptom, or complaint.
- Services covered under Part B of Medicare except for the Part B Medicare deductible or coinsurance.
- Services to members with ICD-9 diagnosis code from 290 to 309 or from 311 to 314. (These services should be billed to the Iowa Plan.)
- Services utilizing investigational or experimental methods.
- Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons.
- Services for nonspecific conditions of distress, such as job dissatisfaction or general unhappiness.
- Services in a medical institution.

C. REIMBURSEMENT

The basis of payment is a schedule of maximum allowances for each procedure covered.

Service will be reimbursed on the basis of time. Enter the number of units with one unit equal to the time as shown in the description for the procedure code. Round units of service to the nearest unit. For example, 7 minutes is rounded to 0 minutes; and 8 minutes is rounded to 15 minutes.

D. PROCEDURE CODES AND NOMENCLATURE

Claim forms must be completed with all required elements. Claims submitted without a procedure code and an ICD-9-CM or DSM IV diagnosis code will be denied. The procedure codes and descriptions are as follows:

Code	Description
	Office or Other Outpatient Facility
H0031	Mental health assessment by non-physician
90801	Psychiatric diagnostic interview
90802	Interactive psychiatric diagnostic interview using play equipment, physical devices language interpreter, or other mechanisms of communication

Code	Description
90804	Individual psychotherapy, insight oriented behavior modifying &/or supportive, in an office or outpatient facility, face to face with the patient approximately 20-30 min
90806	Individual psychotherapy, Insight oriented behavior modification &/or supportive, in an office or outpatient facility, face to face with the patient. Approximately 45-50 min
90808	Individual psychotherapy, insight oriented behavior modification &/or supportive, in an office or outpatient facility, face to face with the patient Individual psychotherapy, insight oriented behavior modifying and/or supportive, in an office or outpatient facility face to face with the patient, approximately 75-80 min
90810	Interactive individual psychotherapy, interactive, using play equipment, physical devises, language interpreter, or other mechanisms of non-verbal communication in an office or outpatient facility, face to face with the patient approximately 20 to 30 min
90812	Interactive individual psychotherapy, interactive, using play equipment, physical devises, language interpreter, or other mechanisms of non-verbal communication in an office or outpatient facility, face to face with the patient approximately 45 to 50 min
90814	Interactive individual psychotherapy, interactive, using play equipment, physical devises, language interpreter, or other mechanisms of non-verbal communication in an office or outpatient facility, face to face with the patient approximately 75 to 80 min
	Residential Care
90816	Individual psychotherapy, insight oriented, behavior modifying &/or supportive, in a residential care setting, face to face with the patient, approximately 20-30 min
90818	Individual psychotherapy, insight oriented, behavior modifying &/or supportive, in a residential care setting, face to face with the patient, approximately 45-50 min
90821	Individual psychotherapy, insight oriented, behavior modifying &/or supportive, in a residential care setting, face to face with the patient, approximately 75-80 min
90823	Individual psychotherapy, interactive, using play equipment, psychical devices, language interpreter, or other mechanisms of non-verbal communication in an residential care setting, face to face with the patient, approximately 20 to 30 minutes
90826	Individual psychotherapy, interactive, using play equipment, psychical devices, language interpreter, or other mechanisms of non-verbal communication in an residential care setting, face to face with the patient, approximately 45 to 50 minutes

Code	Description
90828	Individual psychotherapy, interactive, using play equipment, psychical devices, language interpreter, or other mechanisms of non-verbal communication in an residential care setting, face to face with the patient, approximately 75 to 80 minutes
	Other Psychotherapy
90845	Psychoanalysis
90846	Family psychotherapy (without the patient present)
90847	Family psychotherapy (conjoint psychotherapy) (with the patient present)
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than a multiple-family group)
90857	Interactive group psychotherapy
	Other Procedures
90880	Hypnotherapy
90901	Biofeedback training by any modality
96110	Developmental testing limited, with interpretation and report
	Health and Behavior Assessment / Intervention
96150	Health and behavior assessment (e.g. health-focused clinical interview, behavior observations, psychophysiological monitoring, health-oriented questionnaire) Initial assessment face-to-face with the patient per 15 min
96151	Re-assessment per 15 min
96152	Health and behavior intervention, face-to-face individual per 15 min
96153	Group (2 or more patients) per 15 min
96154	Family (with the patient present) per 15 min
96155	Family (without the patient present) per 15 min
H0004	Behavioral health counseling and therapy, per 15 min
T1027	Family training and counseling for child development, per 15 min

E. CMS-1500 CLAIM FORM

Providers of remedial services shall submit claims using form CMS-1500, *Health Insurance Claim Form* or bill electronically. To view a sample of this form on line, click here.

Providers interested in billing electronically can contact EDISS (Electronic Data Interchange Support Services) at 800-967-7902 or by e-mail at edi@noridian.com.

Electronic media claim (EMC) submitters should also refer to your EMC specifications for claim completion instructions.

The table below contains information that will aid in the completion of the paper claim form. The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual member's situation.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	**REQUIRED** Check the applicable program block.
1a.	INSURED'S ID NUMBER	**REQUIRED** Enter the Medicaid member's Medicaid number, found on the *Medical Assistance Eligibility Card*. The Medicaid "member" is defined as a recipient of services who has Iowa Medicaid coverage. The Medicaid number consists of seven digits followed by a letter, e.g., 1234567A. Verify eligibility by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.
2.	PATIENT'S NAME	**REQUIRED** Enter the last name, first name, and middle initial of the Medicaid member.
3.	PATIENT'S BIRTHDATE	**OPTIONAL** Enter the Medicaid member's birth month, day, year, and sex. Completing this field may expedite processing of your claim.
4.	INSURED'S NAME	**OPTIONAL** For Iowa Medicaid purposes, the member receiving services is always the "insured." If the member is covered through other insurance, the policyholder is the "other insured."
5.	PATIENT'S ADDRESS	**OPTIONAL** Enter the address and phone number of the member, if available.
6.	PATIENT RELATIONSHIP TO INSURED	**OPTIONAL** For Medicaid purposes, the "insured" is always the same as the patient.
7.	INSURED'S ADDRESS	**OPTIONAL** For Medicaid purposes, the "insured" is always the same as the patient.
8.	PATIENT STATUS	**REQUIRED, IF KNOWN** Check boxes corresponding to the patient's current marital and occupational status.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
9a-d.	OTHER INSURED'S NAME, ETC.	**SITUATIONAL** Required if the Medicaid member is covered under other additional insurance. Enter the name of the policyholder of that insurance, as well as the policy or group number, the employer or school name under which coverage is offered, and the name of the plan or program. If 11d is "yes," these boxes must be completed.
10.	IS PATIENT'S CONDITION RELATED TO	**REQUIRED, IF KNOWN** Check the applicable box to indicate whether or not treatment billed on this claim is for a condition that is somehow work-related or accident-related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "yes" and "no" boxes.
10d.	RESERVED FOR LOCAL USE	**OPTIONAL** No entry required.
11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION	**OPTIONAL** For Medicaid purposes, the "insured" is always the same as the patient.
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	**REQUIRED** If the Medicaid member has other insurance, check "yes" and enter payment amount in field 29. If "yes," then boxes 9a-9d must be completed. If there is no other insurance, check "no." If you have received a denial of payment from another insurance, check **both** "yes" and "no" to indicate that there is other insurance, but that the benefits were denied. Proof of denials must be included in the patient record. Request this information from the member. You may also determine if other insurance exists by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902. NOTE: Auditing will be performed on a random basis to ensure correct billing.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** No entry required.
14.	DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY	**SITUATIONAL** Enter the date of the onset of treatment in MM/DD/YY format. For pregnancy, use the date of the last menstrual period (LMP) as the first date. This field is not required for preventative care.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS...	**SITUATIONAL** Required for chiropractors only. Chiropractors must enter the current x-ray date in MM/DD/YY format.
16.	DATES PATIENT UNABLE TO WORK...	**OPTIONAL** No entry required.
17.	NAME OF REFERRING PROVIDER OR OTHER SOURCE	**SITUATIONAL** Required if the referring provider is not enrolled as an Iowa Medicaid provider. "Referring provider" is defined as the healthcare provider that directed the patient to your office.
17a.		**LEAVE BLANK**. The claim will be returned if any information is entered in this field.
17b.	NPI	**SITUATIONAL** Required in the following situations: ♦ If the patient is a MediPASS member and the MediPASS provider authorized service, enter the 10-digit NPI of the referring provider. ♦ If this claim is for consultation, independent laboratory services, or medical equipment, enter the NPI of the referring or prescribing provider. ♦ If the patient is on lock-in and the lock-in provider authorized the service, enter the NPI of the authorizing provider.
18.	HOSPITALIZATION DATES RELATED TO...	**OPTIONAL** No entry required.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
19.	RESERVED FOR LOCAL USE	**OPTIONAL** No entry required. Note that pregnancy is now indicated with a pregnancy diagnosis code in box 21. If you are unable to use a pregnancy diagnosis code in any of the fields in box 21, write in this box "Y – Pregnant."
20.	OUTSIDE LAB	**OPTIONAL** No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	**REQUIRED** Indicate the applicable ICD-9-CM diagnosis codes in order of importance to a maximum of four diagnoses (1-primary, 2-secondary, 3-tertiary, and 4-quaternary). Do **not** enter descriptions. If the patient is pregnant, one of the diagnosis codes must indicate pregnancy. The pregnancy diagnosis codes are as follows: 640 through 648, 670 through 677, V22, V23
22.	MEDICAID RESUBMISSION CODE...	This field will be required at a future date. Instructions will be provided before the requirement is implemented.
23.	PRIOR AUTHORIZATION NUMBER	**SITUATIONAL** If there is a prior authorization, enter the prior authorization number. Obtain the number from the prior authorization form.
24. A	DATE(S) OF SERVICE/NDC	
	TOP SHADED PORTION	**SITUATIONAL** Required for provider-administered drugs. Enter qualifier "N4" followed by the NDC for the drug referenced in 24d (HCPCs). No spaces or symbols should be used in reporting this information.
	LOWER PORTION	**REQUIRED** Enter the month, day, and year under both the "From" and "To" categories for each procedure, service or supply. If the "From-To" dates span more than one calendar month, enter each month on a separate line. Because eligibility is approved on a month-by-month basis, spanning or overlapping billing months could cause the entire claim to be denied.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
24. B	PLACE OF SERVICE	**REQUIRED** Using the chart below, enter the number corresponding to the place service was provided. Do **not** use alphabetic characters. 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room – hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient psychiatric facility 52 Psychiatric facility – partial hospitalization 53 Community mental health center 54 Intermediate care facility/mentally retarded 55 Residential substance abuse treatment facility 56 Psychiatric residential treatment center 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility 65 End-stage renal disease treatment 71 State or local public health clinic 81 Independent laboratory 99 Other unlisted facility
24. C	EMG	**OPTIONAL** No entry required.
24. D	PROCEDURES, SERVICES OR SUPPLIES	**REQUIRED** Enter the codes for each of the dates of service. **Do not** list services for which no fees were charged. Do **not** enter descriptions. Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code or valid Current Procedural Terminology (CPT) codes. When applicable, show HCPCS code modifiers with the HCPCS code.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
24. E	DIAGNOSIS POINTER	**REQUIRED** Indicate the corresponding diagnosis code from field 21 by entering the number of its position, e.g., 3. **Do not** write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	$ CHARGES	**REQUIRED** Enter the usual and customary charge for each line item. The charge must include both dollars and cents.
24. G	DAYS OR UNITS	**REQUIRED** Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the **total minutes** of general anesthesia.
24. H	EPSDT/FAMILY PLANNING	**SITUATIONAL** Enter an "F" if the services on this claim line are for family planning. Enter an "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	ID QUAL.	**LEAVE BLANK**
24. J	RENDERING PROVIDER ID # TOP SHADED PORTION LOWER PORTION	 **LEAVE BLANK** **REQUIRED** Enter the NPI of the provider rendering the service when the NPI given in field 33a does not identify the treating provider.
25.	FEDERAL TAX ID NUMBER	**OPTIONAL** No entry required.
26.	PATIENT'S ACCOUNT NUMBER	**FOR PROVIDER USE** Enter the account number you have assigned to the patient. This field is limited to 10 alpha/numeric characters.
27.	ACCEPT ASSIGNMENT	**OPTIONAL** No entry required.
28.	TOTAL CLAIM CHARGE	**REQUIRED** Enter the total of the line item charges. If more than one claim form is used to bill services performed, total each claim form separately. Do not carry over any charges to another claim form.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
29.	AMOUNT PAID	**SITUATIONAL** Required if the member has other insurance and the insurance has made a payment on the claim. Enter only the amount paid by the other insurance. Do not list member copayments, Medicare payments, or previous Medicaid payments on this claim. Do not submit this claim until you receive a payment or denial from the other carrier. Proof of denial must be kept in the patient record.
30.	BALANCE DUE	**REQUIRED** Enter the amount of total charges less the amount entered in field 29.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	**REQUIRED** Enter the signature of either the provider or the provider's authorized representative and the original filing date. The signatory must be someone who can legally attest to the service provided and can bind the organization to the declarations on the back of this form. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	SERVICE FACILITY LOCATION INFORMATION	**REQUIRED** Enter complete address of the treating or rendering provider.
32a.	NPI	**OPTIONAL** Enter the NPI of the facility where services were rendered.
32b.		**LEAVE BLANK.** The claim will be returned if any information is entered in this field.
33.	BILLING PROVIDER INFO AND PHONE #	**REQUIRED** Enter the name and complete address of the billing provider. NOTE: The address must contain the ZIP code associated with the billing provider's NPI. The ZIP code must match the ZIP code confirmed during NPI verification. To view the confirmed ZIP code, visit imeservices.org.
33a.	NPI	**REQUIRED** Enter the 10-digit NPI of the billing provider.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
33b.		**REQUIRED** Enter "ZZ" followed by the taxonomy code associated with the billing provider's NPI. No spaces or symbols should be used. The taxonomy code must match the taxonomy code confirmed during NPI verification. To view the confirmed taxonomy code, go to imeservices.org.

F. REMITTANCE ADVICE

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting. To view a sample of this form on line, click here.

1. Remittance Advice Explanation

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied, and suspended claims.

- **Paid** indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.
- **Denied** represents all processed claims for which no reimbursement is made.
- **Suspended** reflects claims which are currently in process pending resolution of one or more issues (member eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount.

An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the IME Provider Services Unit with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

2. Remittance Advice Field Descriptions

NO.	FIELD NAME	DESCRIPTION
1.	To:	Billing provider's name as specified on the Medicaid Provider Enrollment Application.
2.	R.A. No.:	Remittance Advice number.
3.	Warr No.:	The sequence number on the check issued to pay this claim.
4.	Date Paid:	Date claim paid.
5.	Prov. Number:	Billing provider's Medicaid (Title XIX) number.
6.	Page:	*Remittance Advice* page number.
7.	Claim Type:	Type of claim used to bill Medicaid.

NO.	FIELD NAME	DESCRIPTION
8.	Claim Status:	Status of following claims: • **Paid**. Claims for which reimbursement is being made. • **Denied**. Claims for which no reimbursement is being made. • **Suspended**. Claims in process. These claims have not yet been paid or denied.
9.	Patient Name	Member's last and first name.
10.	Recip ID	Member's Medicaid (Title XIX) number.
11.	Trans-Control-Number	Transaction control number assigned to each claim by the IME. Please use this number when making claim inquiries.
12.	Billed Amt.	Total charges submitted by provider.
13.	Other Sources	Total amount applied to this claim from other resources, i.e., other insurance or spenddown.
14.	Paid by Mcaid	Total amount of Medicaid reimbursement as allowed for this claim.
15.	Copay Amt.	Total amount of member copayment deducted from this claim.
16.	Med Recd Num	Medical record number as assigned by provider; 10 characters are printable.
17.	EOB	Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of the *Remittance Advice* for explanation of the EOB code.
18.	Line	Line item number.
19.	SVC-Date	The first date of service for the billed procedure.
20.	Proc/Mods	The procedure code for the rendered service.
21.	Units	The number of units of rendered service.
22.	Billed Amt.	Charge submitted by provider for line item.

NO.	FIELD NAME	DESCRIPTION
23.	Other Sources	Amount applied to this line item from other resources, i.e., other insurance, spenddown.
24.	Paid by Mcaid	Amount of Medicaid reimbursement as allowed for this line item.
25.	Copay Amt.	Amount of member copayment deducted for this line item.
26.	Perf. Prov.	Treating provider's Medicaid (Title XIX) number.
27.	S	Allowed charge source code: **B** Billed charge **F** Fee schedule **M** Manually priced **N** Provider charge rate **P** Group therapy **Q** EPSDT total screen over 17 years **R** EPSDT total under 18 years **S** EPSDT partial over 17 years **T** EPSDT partial under 18 years **U** Gynecology fee **V** Obstetrics fee **W** Child fee
28.	Remittance totals	(Found at the end of the *Remittance Advice*): • Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid. • Number of paid adjusted claims, amount billed by the provider, and the amount allowed and reimbursed by Medicaid. • Number of denied original claims and the amount billed by the provider. • Number of denied adjusted claims and the amount billed by the provider. • Number of pended claims (in process) and the amount billed by the provider. • Amount of the check (warrant) written to pay these claims.
29.	Description of EOB code	Lists the individual explanation of benefits codes used, followed by the meaning of the code and advice.

Medicaid Enterprise
Department of Human Services

For Human Services use only:

General Letter No. 8-AP-292
Employees' Manual, Title 8
Medicaid Appendix

December 5, 2008

BEHAVIORAL HEALTH SERVICES MANUAL TRANSMITTAL NO. 08-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Behavioral Health Manual***, Title Page, new; Table of Contents, new;

Chapter I, ***General Program Policies***, Title Page, Table of Contents, pages 1 through 44, and the following forms:

470-4166	*Iowa Medicaid Provider Form Request*
RC-0113	*List of Emergency Diagnosis Codes*
470-3744	*Provider Inquiry*
470-0040	*Credit/Adjustment Request*

Chapter II, ***Member Eligibility***, Title Page, Table of Contents (pages 1 and 2), pages 1 through 33, and the following forms:

470-1911	*Medical Assistance Eligibility Card*
470-2580	*Presumptive Medicaid Eligibility Notice of Decision*
470-4164	*IowaCare Medical Card*
470-2927	*Health Services Application*
470-2927(S)	*Health Services Application (Spanish)*
470-3931	*Medically Needy Expense Deletion Request*
470-4299	*Verification of Emergency Health Care Services*
470-2579	*Application for Authorization to Make Presumptive Medicaid Eligibility Determinations*
470-2582	*Memorandum of Understanding Between the Iowa Department of Human Services and the Qualified Provider*
470-2629	*Presumptive Medicaid Income Calculation*
470-3864	*Application for Authorization to Make Presumptive Medicaid Eligibility Determinations (BCCT)*
470-3865	*Memorandum of Understanding With a Qualified Provider for Breast of Cervical Cancer Treatment*

Chapter III, ***Provider-Specific Policies***, Title Page, new; Table of Contents (pages 1 and 2), new; pages 1 through 17, new; and the following forms:

CMS-1500	*Health Insurance Claim Form*
	Remittance Advice

Appendix, Title Page, Table of Contents, and pages 1 through 18

Summary

This letter transmits a new manual for providers of Behavioral Health services. This new service was mandated by the 2008 General Assembly.

The manual is comprised of four sections:

- Chapter I contains information about Iowa Medicaid administration, coverage, and reimbursement that applies to all types of providers.
- Chapter II describes the different ways of attaining and demonstrating Medicaid eligibility. It also applies to all provider types.
- Chapter III explains Medicaid requirements specific to behavioral health services. The chapter includes information regarding:
  - What services are covered and what requirements apply to them;
  - Provider documentation of services; and
  - The forms and instructions used for billing for behavioral health services.
- The Appendix contains directories of local Department of Human Services offices, Social Security offices in Iowa, and EPSDT care and coordination agencies.

Date Effective

December 1, 2008

Material Superseded

None

Additional Information

The new provider manual can be found at:

www.ime.state.ia.us/providers

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to the Iowa Medicaid Enterprise Provider Services Unit.